

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03881

3882

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u>		COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION TOWN</u>		LENGTH OF STAY (In this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION TOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN DAVID</u> (Middle) <u>ALBAUGH</u> (Last)				(Month) <u>APRIL</u> (Day) <u>11</u> (Year) <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>2/6/1876</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST-FARMER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS A. ALBAUGH</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-14-4840</u>		17. INFORMANT & ADDRESS <u>MAUDE ALBAUGH, UNION TOWN MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-10</u> , 19 <u>57</u> , to <u>4-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-11</u> , 19 <u>57</u> , and that death occurred at <u>4:37</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>J. H. Legg</u>				ADDRESS (Street, city, town, state) <u>Union Bridge MD</u>		DATE SIGNED <u>4-12-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4/14/57</u>		NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
24. REC'D BY REGISTRAR <u>APR 15 1957</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Union Bridge MD</u>	

CERTIFICATE OF DEATH

FILE NO. 12

2. HUSBAND, WIFE, CHILD, OR OTHER PERSON

MARYLAND

CITY OF BALTIMORE

W. J. W. W.

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BUREAU V. S.

APR 15 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3883

CERTIFICATE OF DEATH

03882

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 mos, 17 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 418 Potomac Street	
3. NAME OF DECEASED (Type or print) First Eleanora Middle ALBERT Last ALBERT		4. DATE OF DEATH Month April Day 9 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1862
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months 94 Days 9 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Albert		14. MOTHER'S MAIDEN NAME Mary Katherine Mumma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - 71111	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia unresolved 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 22, 1957 , to April 9, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 4/9/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home R. Franklin Berger		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR 4-15-57		24b. REGISTRAR'S SIGNATURE C. Harry Zelen	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15, 1910		New York City		New York City		Heart Disease		Jan 15, 1957		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		None		Jan 10, 1957		Jan 10, 1957		Jan 15, 1957		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Jan 15, 1957		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.		John Doe, M.D.	

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APR 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3884

CERTIFICATE OF DEATH

03883

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		c. LENGTH OF STAY IN 1b 16 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Hazel Last Baldwin		4. DATE OF DEATH Month April Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1884
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac H. Baldwin		14. MOTHER'S MAIDEN NAME Jane A. Newhouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Lelia G. Baldwin		Address Taneytown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac dilatation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 3 weeks years(?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935 , to 4-23-1957 , that I last saw the deceased alive on 4-22-1957 , and that death occurred at 16A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Stone		DATE SIGNED 4/23/57	
PHYSICIAN'S NAME (Type) W. C. Stone, M.D.		121 E. Green St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-23-57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR DATE 4-24-57		24b. REGISTRAR'S SIGNATURE 14 Carol Miller	

CERTIFICATE OF DEATH

See This Side

BUREAU V. S.

APR 26 1957

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3885

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr. 8mos. 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2235 Kentucky Avenue			
3. NAME OF DECEASED (Type or print) First Benjamin Middle Edward Last BELL				4. DATE OF DEATH Month April Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1859	
9. AGE (In years lost birthday) 97 yrs.		IF UNDER 1 YEAR Months 24 Days 19		IF UNDER 24 HRS. Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Ymk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Bell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ymk		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2-3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Balto.		20h. (State) Md.	
21. I certify that I attended the deceased from 8/3/55 , 19____, to 4/24/57 , 19____, that I last saw the deceased alive on 4/24/57 , 19____, and that death occurred at 8:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				DATE SIGNED 4/24/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF April 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.				ADDRESS Balto., Md.		24a. REC'D BY REGISTRAR DATE 4-24-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Allen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1910	
Place of Birth		Race		Marital Status		Occupation	
New York City		White		Married		Teacher	
Address at Time of Death		Cause of Death		Date of Death		Time of Death	
123 Main St, Baltimore, Md.		Heart Disease		Jan 20, 1955		10:00 AM	
Physician's Name		Hospital Name		Place of Death		Burial Place	
Dr. J. Smith		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 26 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland		c. LENGTH OF STAY IN 1b 56 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Westley Last Belt		4. DATE OF DEATH Month April Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 8, 1904
9. AGE (In years last birthday) yrs. 51 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Belt		14. MOTHER'S MAIDEN NAME Nannie Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George Walter Belt - 118 O'Berry Ct.-Annapolis		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 18, 1957 , to April 15, 1957 , that I last saw the deceased alive on April 15, 1957 , and that death occurred at 12:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 4-15-57 ACTUAL SIGNATURE T. F. Vestal M.D. PHYSICIAN'S NAME (Type) T. F. Vestal, Superintendent Henryton State Hospital, Henryton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-57	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr.		24. REC'D BY REGISTRAR DATE 4-15-57	
ADDRESS Annapolis, Md.		25. REGISTRAR'S SIGNATURE Albert R. Swankhouse	

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APR 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

3887

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>2802 Herkimer Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Bene</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-11</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptometer Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bene</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Tiyekker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liposarcoma of the breast tissue, with metastasis</u> DUE TO <u>with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia, paranoid type</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-8-</u> , 19 <u>42</u> , to <u>4-2-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrud Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital Sykesville Md</u>	
PHYSICIAN'S NAME (Type) <u>Bertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.</u>		DATE SIGNED <u>4/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cn Frederick</u>	22d. LOCATION (City, town, or county) (State) <u>Red Bank</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond Toulson</u>		ADDRESS <u>2359 Wash Blvd Baltimore</u>	
24a. REC'D BY REGISTRAR <u>3</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Kern</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 3 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3888
CERTIFICATE OF DEATH

038887
87

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSHUA</u> Middle <u>LEVERING</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6, 1895</u>
9. AGE (In years last birthday) yrs. <u>61</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Randallstown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John W. Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Ann L. Herbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-4236</u>	
17. INFORMANT <u>Mildred C. Bowen</u> Address <u>Washington Eden Mill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, CARDIAC</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>failure, Arteriosclerosis, OBESITY.</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1945 to April 1957</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH</u> , 1957, to <u>April</u> , 1957, that I last saw the deceased alive on <u>3 April</u> , 1957, and that death occurred at <u>3:30 A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. <u>Sykesville, Md</u> <u>3 April 57</u> PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03888

3889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
3. NAME OF DECEASED (Type or print) First William Middle Brown Last Brown		4. DATE OF DEATH Month 4 Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1907
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY Interior Decorator	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lonzo Brown		14. MOTHER'S MAIDEN NAME Catherine ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT William Brown - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory pulmonary TB. 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10, 19 57 , to April 22, 19 57 , that I last saw the deceased alive on April 22, 19 57 , and that death occurred at 10:05A AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE T. F. Vestal		ADDRESS (Street, city or town, state) Henryton State Hospital, Henryton, Md.	
DATE SIGNED 4/22/57			
PHYSICIAN'S NAME (Type) T. F. Vestal, Superintendent		Henryton State Hospital, Henryton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams		ADDRESS 4-23-57	
24a. REC'D BY REGISTRAR Alburt R. Humphreys		24b. REGISTRAR'S SIGNATURE Alburt R. Humphreys	

CERTIFICATE OF DEATH

STATE OF MARYLAND		COUNTY OF BALTIMORE	
DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF NOTARY		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE CITY CLERK	

BUREAU M. H.

APR 24 1957

RECEIVED

3890

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spysville</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Spysville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elmer</u> (First) <u>Pearl</u> (Middle) <u>Browning</u> (Last)		4. DATE OF DEATH <u>April</u> Month <u>5</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm T. Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Grimmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Betty Glass - Spysville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery, Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arrhythmic Fibrillation, Congestive failure,</u> DUE TO (c) <u>Hypertension,</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1954</u> <u>10</u> <u>1957</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 April</u> , 19 <u>57</u> , and that death occurred at <u>12:45 P</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Spysville, Md</u> DATE SIGNED <u>4-6-57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West View</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth H. Haight - Spysville, Md</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>4-6-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3891

CERTIFICATE OF DEATH

03890

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13, 3801.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3220 Belair Road	
3. NAME OF DECEASED (Type or print) First Charles Middle Plumber Last Burgess		4. DATE OF DEATH Month 4 Day 19 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-73
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Unk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Burgess		14. MOTHER'S MAIDEN NAME Esther Temple	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of sigmoid sinus 341X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with cerebral arterioscler. with psych. reaction		INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-5- , 19 57 , to 4-18- , 19 57 , that I last saw the deceased alive on 4-18- , 19 57 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund B. Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-19-57	
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus M.D.		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR 4-19-57 24b. REGISTRAR'S SIGNATURE C. Harry Allen	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>John Doe, Md.</u></p>	
<p>5. Date of death: <u>Dec 1, 1957</u></p>		<p>6. Place of death: <u>John Doe, Md.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Dec 1, 1957</u></p>		<p>12. Place of registration: <u>John Doe, Md.</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Address of informant: <u>John Doe, Md.</u></p>	
<p>15. Name of informant: <u>John Doe</u></p>		<p>16. Address of informant: <u>John Doe, Md.</u></p>	
<p>17. Name of informant: <u>John Doe</u></p>		<p>18. Address of informant: <u>John Doe, Md.</u></p>	
<p>19. Name of informant: <u>John Doe</u></p>		<p>20. Address of informant: <u>John Doe, Md.</u></p>	
<p>21. Name of informant: <u>John Doe</u></p>		<p>22. Address of informant: <u>John Doe, Md.</u></p>	
<p>23. Name of informant: <u>John Doe</u></p>		<p>24. Address of informant: <u>John Doe, Md.</u></p>	
<p>25. Name of informant: <u>John Doe</u></p>		<p>26. Address of informant: <u>John Doe, Md.</u></p>	
<p>27. Name of informant: <u>John Doe</u></p>		<p>28. Address of informant: <u>John Doe, Md.</u></p>	
<p>29. Name of informant: <u>John Doe</u></p>		<p>30. Address of informant: <u>John Doe, Md.</u></p>	
<p>31. Name of informant: <u>John Doe</u></p>		<p>32. Address of informant: <u>John Doe, Md.</u></p>	
<p>33. Name of informant: <u>John Doe</u></p>		<p>34. Address of informant: <u>John Doe, Md.</u></p>	
<p>35. Name of informant: <u>John Doe</u></p>		<p>36. Address of informant: <u>John Doe, Md.</u></p>	
<p>37. Name of informant: <u>John Doe</u></p>		<p>38. Address of informant: <u>John Doe, Md.</u></p>	
<p>39. Name of informant: <u>John Doe</u></p>		<p>40. Address of informant: <u>John Doe, Md.</u></p>	
<p>41. Name of informant: <u>John Doe</u></p>		<p>42. Address of informant: <u>John Doe, Md.</u></p>	
<p>43. Name of informant: <u>John Doe</u></p>		<p>44. Address of informant: <u>John Doe, Md.</u></p>	
<p>45. Name of informant: <u>John Doe</u></p>		<p>46. Address of informant: <u>John Doe, Md.</u></p>	
<p>47. Name of informant: <u>John Doe</u></p>		<p>48. Address of informant: <u>John Doe, Md.</u></p>	
<p>49. Name of informant: <u>John Doe</u></p>		<p>50. Address of informant: <u>John Doe, Md.</u></p>	
<p>51. Name of informant: <u>John Doe</u></p>		<p>52. Address of informant: <u>John Doe, Md.</u></p>	
<p>53. Name of informant: <u>John Doe</u></p>		<p>54. Address of informant: <u>John Doe, Md.</u></p>	
<p>55. Name of informant: <u>John Doe</u></p>		<p>56. Address of informant: <u>John Doe, Md.</u></p>	
<p>57. Name of informant: <u>John Doe</u></p>		<p>58. Address of informant: <u>John Doe, Md.</u></p>	
<p>59. Name of informant: <u>John Doe</u></p>		<p>60. Address of informant: <u>John Doe, Md.</u></p>	
<p>61. Name of informant: <u>John Doe</u></p>		<p>62. Address of informant: <u>John Doe, Md.</u></p>	
<p>63. Name of informant: <u>John Doe</u></p>		<p>64. Address of informant: <u>John Doe, Md.</u></p>	
<p>65. Name of informant: <u>John Doe</u></p>		<p>66. Address of informant: <u>John Doe, Md.</u></p>	
<p>67. Name of informant: <u>John Doe</u></p>		<p>68. Address of informant: <u>John Doe, Md.</u></p>	
<p>69. Name of informant: <u>John Doe</u></p>		<p>70. Address of informant: <u>John Doe, Md.</u></p>	
<p>71. Name of informant: <u>John Doe</u></p>		<p>72. Address of informant: <u>John Doe, Md.</u></p>	
<p>73. Name of informant: <u>John Doe</u></p>		<p>74. Address of informant: <u>John Doe, Md.</u></p>	
<p>75. Name of informant: <u>John Doe</u></p>		<p>76. Address of informant: <u>John Doe, Md.</u></p>	
<p>77. Name of informant: <u>John Doe</u></p>		<p>78. Address of informant: <u>John Doe, Md.</u></p>	
<p>79. Name of informant: <u>John Doe</u></p>		<p>80. Address of informant: <u>John Doe, Md.</u></p>	
<p>81. Name of informant: <u>John Doe</u></p>		<p>82. Address of informant: <u>John Doe, Md.</u></p>	
<p>83. Name of informant: <u>John Doe</u></p>		<p>84. Address of informant: <u>John Doe, Md.</u></p>	
<p>85. Name of informant: <u>John Doe</u></p>		<p>86. Address of informant: <u>John Doe, Md.</u></p>	
<p>87. Name of informant: <u>John Doe</u></p>		<p>88. Address of informant: <u>John Doe, Md.</u></p>	
<p>89. Name of informant: <u>John Doe</u></p>		<p>90. Address of informant: <u>John Doe, Md.</u></p>	
<p>91. Name of informant: <u>John Doe</u></p>		<p>92. Address of informant: <u>John Doe, Md.</u></p>	
<p>93. Name of informant: <u>John Doe</u></p>		<p>94. Address of informant: <u>John Doe, Md.</u></p>	
<p>95. Name of informant: <u>John Doe</u></p>		<p>96. Address of informant: <u>John Doe, Md.</u></p>	
<p>97. Name of informant: <u>John Doe</u></p>		<p>98. Address of informant: <u>John Doe, Md.</u></p>	
<p>99. Name of informant: <u>John Doe</u></p>		<p>100. Address of informant: <u>John Doe, Md.</u></p>	

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G213 4-12-57 et

3892

CERTIFICATE OF DEATH

03891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. STREET ADDRESS Rt. 1, Box 115, Mt. Vernon			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Burke				4. DATE OF DEATH Month April Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1891	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eddie Burke				14. MOTHER'S MAIDEN NAME Sarah (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-1444		17. INFORMANT Address Russell Burke-Rt. 2, Box 26 Eden, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema Pulmonum 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Failure DUE TO (c) Pulmonary Tuberculosis-Far Advanced						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28 , 1957, to April 6 , 1957, that I last saw the deceased alive on April 6 , 1957, and that death occurred at 12:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED ACTUAL SIGNATURE J.F. V. [Signature] M.D. PHYSICIAN'S NAME (Type) Henryton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/10/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Vernon, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Arthur R. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Md.		14. TIME OF DEATH 11:00 AM		15. DATE OF DEATH 4-4-68	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF DEATH REGISTRAR J. Edgar Hoover		19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF DECEASED J. Edgar Hoover	
21. SIGNATURE OF DECEASED J. Edgar Hoover		22. SIGNATURE OF DECEASED J. Edgar Hoover		23. SIGNATURE OF DECEASED J. Edgar Hoover		24. SIGNATURE OF DECEASED J. Edgar Hoover		25. SIGNATURE OF DECEASED J. Edgar Hoover	
26. SIGNATURE OF DECEASED J. Edgar Hoover		27. SIGNATURE OF DECEASED J. Edgar Hoover		28. SIGNATURE OF DECEASED J. Edgar Hoover		29. SIGNATURE OF DECEASED J. Edgar Hoover		30. SIGNATURE OF DECEASED J. Edgar Hoover	
31. SIGNATURE OF DECEASED J. Edgar Hoover		32. SIGNATURE OF DECEASED J. Edgar Hoover		33. SIGNATURE OF DECEASED J. Edgar Hoover		34. SIGNATURE OF DECEASED J. Edgar Hoover		35. SIGNATURE OF DECEASED J. Edgar Hoover	
36. SIGNATURE OF DECEASED J. Edgar Hoover		37. SIGNATURE OF DECEASED J. Edgar Hoover		38. SIGNATURE OF DECEASED J. Edgar Hoover		39. SIGNATURE OF DECEASED J. Edgar Hoover		40. SIGNATURE OF DECEASED J. Edgar Hoover	
41. SIGNATURE OF DECEASED J. Edgar Hoover		42. SIGNATURE OF DECEASED J. Edgar Hoover		43. SIGNATURE OF DECEASED J. Edgar Hoover		44. SIGNATURE OF DECEASED J. Edgar Hoover		45. SIGNATURE OF DECEASED J. Edgar Hoover	
46. SIGNATURE OF DECEASED J. Edgar Hoover		47. SIGNATURE OF DECEASED J. Edgar Hoover		48. SIGNATURE OF DECEASED J. Edgar Hoover		49. SIGNATURE OF DECEASED J. Edgar Hoover		50. SIGNATURE OF DECEASED J. Edgar Hoover	
51. SIGNATURE OF DECEASED J. Edgar Hoover		52. SIGNATURE OF DECEASED J. Edgar Hoover		53. SIGNATURE OF DECEASED J. Edgar Hoover		54. SIGNATURE OF DECEASED J. Edgar Hoover		55. SIGNATURE OF DECEASED J. Edgar Hoover	
56. SIGNATURE OF DECEASED J. Edgar Hoover		57. SIGNATURE OF DECEASED J. Edgar Hoover		58. SIGNATURE OF DECEASED J. Edgar Hoover		59. SIGNATURE OF DECEASED J. Edgar Hoover		60. SIGNATURE OF DECEASED J. Edgar Hoover	
61. SIGNATURE OF DECEASED J. Edgar Hoover		62. SIGNATURE OF DECEASED J. Edgar Hoover		63. SIGNATURE OF DECEASED J. Edgar Hoover		64. SIGNATURE OF DECEASED J. Edgar Hoover		65. SIGNATURE OF DECEASED J. Edgar Hoover	
66. SIGNATURE OF DECEASED J. Edgar Hoover		67. SIGNATURE OF DECEASED J. Edgar Hoover		68. SIGNATURE OF DECEASED J. Edgar Hoover		69. SIGNATURE OF DECEASED J. Edgar Hoover		70. SIGNATURE OF DECEASED J. Edgar Hoover	
71. SIGNATURE OF DECEASED J. Edgar Hoover		72. SIGNATURE OF DECEASED J. Edgar Hoover		73. SIGNATURE OF DECEASED J. Edgar Hoover		74. SIGNATURE OF DECEASED J. Edgar Hoover		75. SIGNATURE OF DECEASED J. Edgar Hoover	
76. SIGNATURE OF DECEASED J. Edgar Hoover		77. SIGNATURE OF DECEASED J. Edgar Hoover		78. SIGNATURE OF DECEASED J. Edgar Hoover		79. SIGNATURE OF DECEASED J. Edgar Hoover		80. SIGNATURE OF DECEASED J. Edgar Hoover	
81. SIGNATURE OF DECEASED J. Edgar Hoover		82. SIGNATURE OF DECEASED J. Edgar Hoover		83. SIGNATURE OF DECEASED J. Edgar Hoover		84. SIGNATURE OF DECEASED J. Edgar Hoover		85. SIGNATURE OF DECEASED J. Edgar Hoover	
86. SIGNATURE OF DECEASED J. Edgar Hoover		87. SIGNATURE OF DECEASED J. Edgar Hoover		88. SIGNATURE OF DECEASED J. Edgar Hoover		89. SIGNATURE OF DECEASED J. Edgar Hoover		90. SIGNATURE OF DECEASED J. Edgar Hoover	
91. SIGNATURE OF DECEASED J. Edgar Hoover		92. SIGNATURE OF DECEASED J. Edgar Hoover		93. SIGNATURE OF DECEASED J. Edgar Hoover		94. SIGNATURE OF DECEASED J. Edgar Hoover		95. SIGNATURE OF DECEASED J. Edgar Hoover	
96. SIGNATURE OF DECEASED J. Edgar Hoover		97. SIGNATURE OF DECEASED J. Edgar Hoover		98. SIGNATURE OF DECEASED J. Edgar Hoover		99. SIGNATURE OF DECEASED J. Edgar Hoover		100. SIGNATURE OF DECEASED J. Edgar Hoover	

BUREAU V. 2

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG214 4-29-57 et

3893

CERTIFICATE OF DEATH

Reg. Dist. No.

03892

174

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland				c. LENGTH OF STAY IN 1b 7yrs. 2mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Virginia Middle Pearl Last Clifford				4. DATE OF DEATH Month 4 Day 12 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music teacher			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Keene Clifford				14. MOTHER'S MAIDEN NAME Mary Virginia Dobson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalized arteriosclerosis DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-11-50 , 19 50 , to 4-12- , 19 57 , that I last saw the deceased alive on 4-12- , 19 57 , and that death occurred at 3:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-12-57 ACTUAL SIGNATURE M. N. Mastin M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) M. N. Mastin, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE William A. Haight - Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 4-16-57		24b. REGISTRAR'S SIGNATURE C. Harry Wick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

APR 18 1957

RECEIVED

3891

CERTIFICATE OF DEATH

Reg. Dist. No.

174

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville x 2</u>	
c. LENGTH OF STAY IN 1b <u>15 years</u>		d. STREET ADDRESS <u>Oakland Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakland Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melissa</u> Middle <u>Ann</u> Last <u>Conaway</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 1884</u> yrs. <u>72</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Esther Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-2405</u>	
17. INFORMANT <u>Mr Walter McDaniel - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>350x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>57</u> , to <u>8 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 April</u> , 19 <u>57</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>4.8.57</u>			
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr., M.D.</u>		M.D. <u>Liberty Road at Eldersburg</u> <u>4.8.57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant</u>	22d. LOCATION (City, town, or county) (State) <u>Shader, Carroll Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>		ADDRESS <u>Sykesville P.O., Maryland</u>	
24a. REC'D BY REGISTRAR <u>4-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1957

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

3895

CERTIFICATE OF DEATH

Reg. Dist. No. 748

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westminster				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES MARSHALL COOK				4. DATE OF DEATH Month APRIL Day 15 Year 19 57			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Cook				14. MOTHER'S MAIDEN NAME Phoebe Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 229-12-7168		17. INFORMANT Address Mrs. Evelyn Gibson, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 480x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia DUE TO (c) Chronic Nephrocarditis						INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4/10 , 19 57 , to 4/15 , 19 57 , that I last saw the deceased alive on 4/15 , 19 57 , and that death occurred at 11 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur Bare				ADDRESS (Street, city or town, state) Baltimore, Maryland			
PHYSICIAN'S NAME (Type) SOLUTHER BARE				DATE SIGNED 4/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-19-1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Carroll CO., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24. REC'D BY REGISTRAR APR 22 1957	
				24b. REGISTRAR'S SIGNATURE May 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 22 1957

RECEIVED

3898

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>COTINGAME</u> Middle <u>COTINGAME</u> Last		4. DATE OF DEATH <u>4</u> Month <u>11</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 15-1878</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RT. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>NY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R.W. COTINGAME</u>		14. MOTHER'S MAIDEN NAME <u>SYNTHIA SIZEMORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOHN COTINGAME WESTMINSTER, MD.</u> Address <u>R.D. 3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 11, 1957</u> , to <u>April 11, 1957</u> , that I last saw the deceased alive on <u>April 11, 1957</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foward</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u> DATE SIGNED <u>4/12/57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foward</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-15-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWBROOK CEM. WESTMINSTER</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bannard Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>4-16-57</u> 24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME LAST, FIRST, MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE AGE <input type="text"/> YEARS <input type="text"/> MONTHS <input type="text"/> DAYS DATE OF BIRTH <input type="text"/>		DECEASED'S SEX SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE AGE <input type="text"/> YEARS <input type="text"/> MONTHS <input type="text"/> DAYS DATE OF BIRTH <input type="text"/>	
DECEASED'S RESIDENCE STREET <input type="text"/> CITY <input type="text"/> STATE <input type="text"/>		DECEASED'S OCCUPATION OCCUPATION <input type="text"/>	
DECEASED'S MARITAL STATUS MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		DECEASED'S RACE RACE <input type="text"/>	
DECEASED'S RELIGION RELIGION <input type="text"/>		DECEASED'S ETHNIC ORIGIN ETHNIC ORIGIN <input type="text"/>	
DECEASED'S EDUCATION EDUCATION <input type="text"/>		DECEASED'S MANNER OF DEATH MANNER OF DEATH <input type="text"/>	
DECEASED'S CAUSE OF DEATH CAUSE OF DEATH <input type="text"/>		DECEASED'S PLACE OF DEATH PLACE OF DEATH <input type="text"/>	
DECEASED'S DATE OF DEATH DATE OF DEATH <input type="text"/>		DECEASED'S TIME OF DEATH TIME OF DEATH <input type="text"/>	
DECEASED'S SIGNATURE SIGNATURE <input type="text"/>		DECEASED'S ADDRESS ADDRESS <input type="text"/>	
DECEASED'S PHONE NUMBER PHONE NUMBER <input type="text"/>		DECEASED'S SOCIAL SECURITY NUMBER SOCIAL SECURITY NUMBER <input type="text"/>	
DECEASED'S MARITAL STATUS MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		DECEASED'S RACE RACE <input type="text"/>	
DECEASED'S ETHNIC ORIGIN ETHNIC ORIGIN <input type="text"/>		DECEASED'S MANNER OF DEATH MANNER OF DEATH <input type="text"/>	
DECEASED'S CAUSE OF DEATH CAUSE OF DEATH <input type="text"/>		DECEASED'S PLACE OF DEATH PLACE OF DEATH <input type="text"/>	
DECEASED'S DATE OF DEATH DATE OF DEATH <input type="text"/>		DECEASED'S TIME OF DEATH TIME OF DEATH <input type="text"/>	
DECEASED'S SIGNATURE SIGNATURE <input type="text"/>		DECEASED'S ADDRESS ADDRESS <input type="text"/>	
DECEASED'S PHONE NUMBER PHONE NUMBER <input type="text"/>		DECEASED'S SOCIAL SECURITY NUMBER SOCIAL SECURITY NUMBER <input type="text"/>	

BUREAU V. 3

1957 12 18

RECEIVED

3897

CERTIFICATE OF DEATH

03896
81

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) <u>OLIVE</u> First <u>MARGARET</u> Middle <u>CRUSHONG</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24-1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WILLIAM T METZ</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE B KEENEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-14-6594</u>			
17. INFORMANT <u>ELLIS CRUSHONG</u>				Address <u>UNION BRIDGE RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>7/6, 1956</u> to <u>4/26, 1957</u> , that I last saw the deceased alive on <u>4/26, 1957</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				M.D. <u>New Windsor, Md.</u>			
PHYSICIAN'S NAME (Type) <u>M. E. Robertson M.D.</u>				DATE SIGNED <u>4/26/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>REFORMED</u>		22d. LOCATION (City, town, or county) (State) <u>TANEY TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler</u>				ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>APR 30 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Leah Z. Reppas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3898

CERTIFICATE OF DEATH

03897

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15x22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elwood Middle Richard Last Davis				4. DATE OF DEATH Month 4 Day 7 Year 1957			
5. SEX male		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-23	
9. AGE (In years last birthday) yrs. 33		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cement Worker		11. BIRTHPLACE (State or foreign country) Charles Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Da vis		14. MOTHER'S MAIDEN NAME Catherine Everhart(Kelly)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-20-6226		17. INFORMANT Rosetta Davis		Address Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonitis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Tuberculosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 4-7 , 19 57 , to 4-7 , 19 57 , that I last saw the deceased alive on 4-7 , 19 57 , and that death occurred at 6.10P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE T.F. Vestal M.D. Henryton, Md. PHYSICIAN'S NAME (Type) T.F. Vestal Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-57		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville Md		24a. REC'D BY REGISTRAR DATE 4-7-57	
24b. REGISTRAR'S SIGNATURE Albert R. Swann							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968		APR 5 1968	

RECEIVED
 APR 9 1967
 BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

03898

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3 mo 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01022	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 14 Marion Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pauline Middle Virginia Last Davis				4. DATE OF DEATH Month 4 Day 27 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-07		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Lizer				14. MOTHER'S MAIDEN NAME Blanch Haugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn		16. SOCIAL SECURITY NO. Unkn		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia due to undetermined cause DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with cerebral arteriosclerosis with psych. react.						INTERVAL BETWEEN ONSET AND DEATH years weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-21-57 , 19 57 , to 4-27 , 19 57 , that I last saw the deceased alive on 1-26- , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-27-57							
ACTUAL SIGNATURE Edmund B. Lusthaus M.D.				DATE SIGNED 4-27-57			
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus				ADDRESS Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Allen, Inc.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 4-28-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Ziska			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>John Doe</u></p>	
<p>5. Date of death: <u>Jan 1, 1950</u></p>		<p>6. Place of death: <u>John Doe</u></p>	
<p>7. Cause of death: <u>John Doe</u></p>		<p>8. Manner of death: <u>John Doe</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Jan 1, 1950</u></p>		<p>12. Place of registration: <u>John Doe</u></p>	
<p>13. Signature of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>John Doe</u></p>	
<p>15. Signature of registrar: <u>John Doe</u></p>		<p>16. Signature of registrar: <u>John Doe</u></p>	
<p>17. Signature of registrar: <u>John Doe</u></p>		<p>18. Signature of registrar: <u>John Doe</u></p>	
<p>19. Signature of registrar: <u>John Doe</u></p>		<p>20. Signature of registrar: <u>John Doe</u></p>	
<p>21. Signature of registrar: <u>John Doe</u></p>		<p>22. Signature of registrar: <u>John Doe</u></p>	
<p>23. Signature of registrar: <u>John Doe</u></p>		<p>24. Signature of registrar: <u>John Doe</u></p>	
<p>25. Signature of registrar: <u>John Doe</u></p>		<p>26. Signature of registrar: <u>John Doe</u></p>	
<p>27. Signature of registrar: <u>John Doe</u></p>		<p>28. Signature of registrar: <u>John Doe</u></p>	
<p>29. Signature of registrar: <u>John Doe</u></p>		<p>30. Signature of registrar: <u>John Doe</u></p>	
<p>31. Signature of registrar: <u>John Doe</u></p>		<p>32. Signature of registrar: <u>John Doe</u></p>	
<p>33. Signature of registrar: <u>John Doe</u></p>		<p>34. Signature of registrar: <u>John Doe</u></p>	
<p>35. Signature of registrar: <u>John Doe</u></p>		<p>36. Signature of registrar: <u>John Doe</u></p>	
<p>37. Signature of registrar: <u>John Doe</u></p>		<p>38. Signature of registrar: <u>John Doe</u></p>	
<p>39. Signature of registrar: <u>John Doe</u></p>		<p>40. Signature of registrar: <u>John Doe</u></p>	
<p>41. Signature of registrar: <u>John Doe</u></p>		<p>42. Signature of registrar: <u>John Doe</u></p>	
<p>43. Signature of registrar: <u>John Doe</u></p>		<p>44. Signature of registrar: <u>John Doe</u></p>	
<p>45. Signature of registrar: <u>John Doe</u></p>		<p>46. Signature of registrar: <u>John Doe</u></p>	
<p>47. Signature of registrar: <u>John Doe</u></p>		<p>48. Signature of registrar: <u>John Doe</u></p>	
<p>49. Signature of registrar: <u>John Doe</u></p>		<p>50. Signature of registrar: <u>John Doe</u></p>	
<p>51. Signature of registrar: <u>John Doe</u></p>		<p>52. Signature of registrar: <u>John Doe</u></p>	
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<p>55. Signature of registrar: <u>John Doe</u></p>		<p>56. Signature of registrar: <u>John Doe</u></p>	
<p>57. Signature of registrar: <u>John Doe</u></p>		<p>58. Signature of registrar: <u>John Doe</u></p>	
<p>59. Signature of registrar: <u>John Doe</u></p>		<p>60. Signature of registrar: <u>John Doe</u></p>	
<p>61. Signature of registrar: <u>John Doe</u></p>		<p>62. Signature of registrar: <u>John Doe</u></p>	
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<p>69. Signature of registrar: <u>John Doe</u></p>		<p>70. Signature of registrar: <u>John Doe</u></p>	
<p>71. Signature of registrar: <u>John Doe</u></p>		<p>72. Signature of registrar: <u>John Doe</u></p>	
<p>73. Signature of registrar: <u>John Doe</u></p>		<p>74. Signature of registrar: <u>John Doe</u></p>	
<p>75. Signature of registrar: <u>John Doe</u></p>		<p>76. Signature of registrar: <u>John Doe</u></p>	
<p>77. Signature of registrar: <u>John Doe</u></p>		<p>78. Signature of registrar: <u>John Doe</u></p>	
<p>79. Signature of registrar: <u>John Doe</u></p>		<p>80. Signature of registrar: <u>John Doe</u></p>	
<p>81. Signature of registrar: <u>John Doe</u></p>		<p>82. Signature of registrar: <u>John Doe</u></p>	
<p>83. Signature of registrar: <u>John Doe</u></p>		<p>84. Signature of registrar: <u>John Doe</u></p>	
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<p>95. Signature of registrar: <u>John Doe</u></p>		<p>96. Signature of registrar: <u>John Doe</u></p>	
<p>97. Signature of registrar: <u>John Doe</u></p>		<p>98. Signature of registrar: <u>John Doe</u></p>	
<p>99. Signature of registrar: <u>John Doe</u></p>		<p>100. Signature of registrar: <u>John Doe</u></p>	

RECEIVED
APR 30 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3900

CERTIFICATE OF DEATH

03899

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 10112			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1208 N. Market Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Lee</u> Last <u>DEERY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-65</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant - ret. farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Phillip Deery</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Springfield State Hosp. records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with cerebral arteriosclerosis, psychotic reaction.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 24, 1956</u> , to <u>April 3, 1957</u> , that I last saw the deceased alive on <u>April 3, 1957</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin Cross</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Martin Cross, M.D.</u>				DATE SIGNED <u>4-3-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-6-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Luth. Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Bolivar-West Virginia</u>				22e. (State) <u>West Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Clune & Son</u>				ADDRESS <u>Frederick-Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5 April 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY OR TOWN	
5. STREET		6. HOUSE NO.	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. OCCUPATION	
11. MARITAL STATUS		12. CAUSE OF DEATH	
13. PLACE OF BIRTH		14. DATE OF BIRTH	
15. NAME OF PHYSICIAN		16. NAME OF FUNERAL HOME	
17. NAME OF MINISTER		18. NAME OF BURIAL PLACE	
19. NAME OF CEMETERY		20. NAME OF INTERMENT	
21. NAME OF BURIAL PLACE		22. NAME OF INTERMENT	
23. NAME OF BURIAL PLACE		24. NAME OF INTERMENT	
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91. NAME OF BURIAL PLACE		92. NAME OF INTERMENT	
93. NAME OF BURIAL PLACE		94. NAME OF INTERMENT	
95. NAME OF BURIAL PLACE		96. NAME OF INTERMENT	
97. NAME OF BURIAL PLACE		98. NAME OF INTERMENT	
99. NAME OF BURIAL PLACE		100. NAME OF INTERMENT	

BUREAU V. S.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03900

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CLARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION TOWN</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>J. SNADER</u> First Middle Last		4. DATE OF DEATH <u>APRIL 12 1957</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED - OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. THOMAS DEVILBISS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA SNADER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>T. DEVILBISS</u> Address <u>UNION TOWN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-6-</u> , 19 <u>57</u> , to <u>4-11-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-11-</u> , 19 <u>57</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Bridge</u> DATE SIGNED <u>4-12-57</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u>		<u>Union Bridge Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>UNION TOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley & Sons, New Windsor Md.</u>		24a. REC'D BY REGISTRAR <u>APR 15 1957</u> 24b. REGISTRAR'S SIGNATURE <u>A. H. Sedwick</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurriness.

Government Laboratories

Group

BUREAU V. S.

APR 15 1957

RECEIVED

T.H. J. & W.D.
J.M. & J.D.
H-11-21
2-6-21
4-11-21

3878

CERTIFICATE OF DEATH

03901

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 172 W. Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Alexander Last Early				4. DATE OF DEATH Month April Day 27 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harrisonburg, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Early				14. MOTHER'S MAIDEN NAME Hannah Mary Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-0303		17. INFORMANT Mrs. George A. Early Address 172 W. Main St. Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia & Cachexia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 759 hrs 6 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 57 , to April 27 , 19 57 , that I last saw the deceased alive on April 27 , 19 57 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. L. Speicher				ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 4/29/57			
PHYSICIAN'S NAME (Type) W. L. Speicher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery		22d. LOCATION (City, town, or county) (State) Westminster Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. ADDRESS Westminster, Md.				24a. REC'D BY REGISTRAR DATE 4-29-57		24b. REGISTRAR'S SIGNATURE H. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. SIGNATURE OF CLERK</p>		<p>19. SIGNATURE OF CHIEF CLERK</p>		<p>20. SIGNATURE OF ASSISTANT CLERK</p>	

BUREAU V. S.

MAY 1 1957

RECEIVED

3879 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN lb 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Tom First Evans Middle Last				4. DATE OF DEATH April Month 24 Day 1957 Year			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-4-1902	
9. AGE (In years last birthday) 55 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sells Seafood		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Joe Evans				14. MOTHER'S MAIDEN NAME Emma ??			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Tom Evans - Patient Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous lymph adenitis (biopsy) 015X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abdominal malignancy diagnosed from cells in asetic fluid. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 4 , 1957, to April 24 , 1957, that I last saw the deceased alive on April 24 , 1957, and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 4-24-57 ACTUAL SIGNATURE T.F. Vestal M.D. Henryton, Maryland PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal, Supt. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell ADDRESS Pikesville				24a. REC'D BY REGISTRAR 4-29-57		24b. REGISTRAR'S SIGNATURE Albert R. Swann	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF CHURCH [Faint text]</p>		<p>16. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>17. SIGNATURE OF CEMETERY [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	

RECEIVED
 APR 30 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03903

3902 CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY XXX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
c. LENGTH OF STAY IN 1b 3 days visiting		d. STREET ADDRESS 3715 Mary Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle O. Last Fitz		4. DATE OF DEATH Month April Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Orange Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Taylor		14. MOTHER'S MAIDEN NAME Margaret Keenan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John B. Fitz, RFD 1, Finksburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensated Arteriosclerosis C-V Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis INTERVAL BETWEEN ONSET AND DEATH 7 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Apr. 23 , 19 57 , to Apr. 25 , 19 57 that I last saw the deceased alive on Apr. 24 , 19 57 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 4-26-57 ACTUAL SIGNATURE D. D. Caples M.D. Reisterstown, Md. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF April 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Clondalltown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harriet Mulvey		24a. REC'D BY REGISTRAR DATE 4-28-57	
24b. REGISTRAR'S SIGNATURE Harriet Mulvey			

33 3 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
CANNON		1957	
AGE		SEX	
100		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
FARMER		HEART DISEASE	
PLACE OF DEATH		DATE OF BURIAL	
HOME		1957	
CITY		COUNTY	
BATHINGORE		ANYLAND	
STATE		COUNTRY	
ANYLAND		UNITED STATES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		TIME	
1957		10:00 AM	
PLACE		CITY	
HOME		BATHINGORE	
STATE		COUNTRY	
ANYLAND		UNITED STATES	

RECEIVED
APR 30 1957
BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03904

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FINKSBURG</u>		<u>70 YRS</u>		TOWN <u>FINKSBURG</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SANDY MOUNT RD.</u>				STREET ADDRESS (If rural give location) <u>SANDY MOUNT RD.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELLA</u> (Middle) <u>MAE</u> (Last) <u>FLATER</u>				(Month) <u>APRIL</u> (Day) <u>26</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 28, 1886</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>John T. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Devilbiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT & ADDRESS <u>F. Marion Flater Finksburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>						<u>24 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA COLON</u>						<u>3 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROTIC C.V. DISEASE</u>						<u>YRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Nov. '54</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA COLON</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 1, 1957</u> , to <u>APRIL 26, 1957</u> , that I last saw the deceased alive on <u>APRIL 25, 1957</u> , and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Stobel</u>				DATE SIGNED <u>4/26/57</u>			
ADDRESS (Street, city, town, state) <u>REISTERSTOWN, MD.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-28-57</u>		NAME OF CEMETERY OR CREMATORY <u>Sandymount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Sandymount, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Muller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Byers</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>4-29-57</u>							

MAY 1 1957

RECEIVED

3904

CERTIFICATE OF DEATH

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				d. STREET ADDRESS <u>MAIN ST</u>			
3. NAME OF DECEASED (Type or print) <u>GEORGE STERLING FOGLE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/1919</u>		9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR - SHOE MFG</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE M. FOGLE</u>				14. MOTHER'S MAIDEN NAME <u>MERLE ERNST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-1004</u>		17. INFORMANT <u>G. M. FOGLE</u> Address <u>UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration</u> <u>502.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Purulent Bronchitis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>4-8</u> , 19 <u>57</u> , to <u>4-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-14</u> , 19 <u>57</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge, Md.</u> DATE SIGNED <u>4-15-57</u>			
PHYSICIAN'S NAME (Type) <u>J. H. LEGG MD</u>				ADDRESS <u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAUST CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Harkley Sons, Union Bridge, Md.</u>				24. REC'D BY REGISTRAR <u>DATE 4/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>John P. Reps</u>	

BUREAU V. S.

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Filing 211 1-25-57 et

CERTIFICATE OF DEATH

03906

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 CHARLES</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE HENRY FOWLER</u>				4. DATE OF DEATH <u>2</u> Month <u>13</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES FOWLER</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE TINGLING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-07-0988</u>			
17. INFORMANT <u>CHARLES M. FOWLER</u>				Address <u>72 CHARLES WESTMINSTER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia & Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vas Disease</u> DUE TO <u>Hypertension</u> (c) <u>Asphyxiation</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>X</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>	
20f. (City or town) <u>X</u> (County) (State)							
21. I certify that I attended the deceased from <u>4-5-52</u> , 1952, to <u>4-13-</u> , 1957, that I last saw the deceased alive on <u>4-13-</u> , 1957, and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. C. Storn</u>				DATE SIGNED <u>121 F 12 1957</u>			
PHYSICIAN'S NAME (Type) <u>Westminster</u>				M.D. <u>Westminster</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard Westminster</u>				24a. REC'D BY REGISTRAR <u>DATE 4-16-57</u>			
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

APR 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

3906

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				d. STREET ADDRESS <u>c/o P.O.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Hezekiah</u> Last <u>Gibbs</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Hayden, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abraham Gibbs</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>221-14-8414A</u>		17. INFORMANT Address <u>Viola G. Henry - 116 1/2 E. 13th St., Chester, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Insufficiency</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Far Advanced Bilateral Pulmonary Tuberculosis</u> DUE TO <u>with Cavitation</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Mid 1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 12</u> , 19 <u>57</u> , to <u>April 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>57</u> , and that death occurred at <u>12:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4-4-57</u> ACTUAL SIGNATURE <u>T.F. Vestal</u> M.D. <u>Henryton, Maryland</u> PHYSICIAN'S NAME (Type) <u>T. F. Vestal, Supt.</u> <u>Henryton State Hospital, Henryton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-4-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Albert R. Swankhouse</u>							

RECEIVED

3907

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R 1 Brown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Isaac Last Green				4. DATE OF DEATH Month April Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer				10b. KIND OF BUSINESS OR INDUSTRY Congoleum Mfg.		11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Dennis Green				14. MOTHER'S MAIDEN NAME Grace Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 216-07-3850			
17. INFORMANT Address Mrs. Etta A. Green R 1 Finksburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Several days Several mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 23, 1957 , to April 23, 1957 , that I last saw the deceased alive on April 23, 1957 , and that death occurred on April 23, 1957 , from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) W. G. Speicher, M.D.				ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 4/24/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-26-57		22c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Garden	
22d. LOCATION (City, town, or county) (State) Finksburg, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.				24a. REC'D BY REGISTRAR DATE 4-25-57		24b. REGISTRAR'S SIGNATURE Harriet Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uniontown</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uniontown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alverta</u> Middle <u>Stuller</u> Last <u>Haines</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 18, 1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John S. Stuller</u>				14. MOTHER'S MAIDEN NAME <u>Annie Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hilbert Stuller, Showell, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUFFOCATION - By Hanging</u> <u>974x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged by neck</u>					
20c. TIME OF INJURY Hour <u>7</u> a. m. <u> </u> Month, Day, Year <u>4-29-1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Uniontown</u>		(County) <u>Carroll</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James J. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/29/57</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> <u>Merwyn C. Fuss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 1 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Director		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Interment		18. Signature of Burial	
19. Signature of Reinterment		20. Signature of Cremation		21. Signature of Disposition	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

RECEIVED
JUN 1 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3909

CERTIFICATE OF DEATH

03910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN IB Since 1-8-1911			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Yunk			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last HARPER				4. DATE OF DEATH Month April Day 11 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teamster		10b. KIND OF BUSINESS OR INDUSTRY Yunk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Harper				14. MOTHER'S MAIDEN NAME Ida Wilhelm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yunk		17. INFORMANT Records of Springfield State Hospital Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 052X (b) Erysipelas of left leg DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Paresis, Central Nervous System Syphilis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from January 8, 1911 , to April 11, 1957 , that I last saw the deceased alive on April 11, 1957 , and that death occurred at 11:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Gross				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4-11-57	
PHYSICIAN'S NAME (Type) Martin Gross, M. D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-57		22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Height - Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 4-12-57		24b. REGISTRAR'S SIGNATURE C. H. H. H.	

CERTIFICATE OF DEATH

30-13

Form 100-101

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS MARRIAGES [Illegible]		PREVIOUS DEATHS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	
PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	
PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	

BUREAU V. 2

APR 16 1957

RECEIVED

3910

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>				c. LENGTH OF STAY IN 1b <u>5 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>134 S MAIN ST</u>				d. STREET ADDRESS <u>1 134 S. Main</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Virginia HARRIS</u>				4. DATE OF DEATH Month Day Year <u>April 2 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30 1870</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Jacob Freyer</u>				14. MOTHER'S MAIDEN NAME <u>Emma Chroweith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Theo E Harris, Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease.</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov 28</u> , 19 <u>56</u> , to <u>April 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>57</u> , and that death occurred at <u>1:15</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>		DATE SIGNED <u>4/2/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>HAMPSTEAD MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grave Run</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Gipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/2/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Henry J. Bush</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

BUREAU A.

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03912

3911

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville, Maryland				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle Belle Last Haupt				4. DATE OF DEATH Month 4 Day 4 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-1881	
9. AGE (In years last birthday) yrs. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 4444ger		10b. KIND OF BUSINESS OR INDUSTRY Cafeteria		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edgar Lankford			
14. MOTHER'S MAIDEN NAME Ella Belle Overton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Ynk				17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 min. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Carroll		20h. (State) Maryland	
21. I certify that I attended the deceased from March 13 , 19 57 , to April 4 , 19 57 , that I last saw the deceased alive on April 4 , 19 57 , and that death occurred at 11:15 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Gertrude M. Gross, M.D. PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-57		22c. NAME OF CEMETERY OR CREMATORY Good Hope		22d. LOCATION (City, town, or county) (State) BALTO Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc				24a. REC'D BY REGISTRAR 1217 St Paul		24b. REGISTRAR'S SIGNATURE C. Harry Elmer	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

APR 8 1957

RECEIVED

BOOK NO. 1710-21

3912

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>3mo., 28days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Blaine</u> Last <u>HERTZLER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-00</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Hertzler</u>				14. MOTHER'S MAIDEN NAME <u>Sara</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT <u>Records from Springfield State Hospital - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Enlargement of the Heart</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Approx. 10 years</u> <u>10 years+</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 1, 1956</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin Gross</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>4-2-57</u>	
PHYSICIAN'S NAME (Type) <u>MARTIN GROSS, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4-5-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-4-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Weller</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3913

CERTIFICATE OF DEATH

Reg. Dist. No.

03914
(03914)
74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Thomas Last HEWITT				4. DATE OF DEATH Month April Day 24 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1870	9. AGE (In years lost birthday) yrs. 86	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - Unknown Meter Reader				10b. KIND OF BUSINESS OR INDUSTRY Sub. San. Commission		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Hewitt				14. MOTHER'S MAIDEN NAME Julie Dowling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease. Broncho-							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pneumonia.			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 13, 1957 , to April 24, 1957 , that I last saw the deceased alive on April 24, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4/24/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 4-27-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Eker			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HENRY		45		M		W		1957		BALTIMORE, MARYLAND	
RESIDENT OF		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE, MARYLAND		1912		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		HISTORY	
LABORER		HEART DISEASE		NATURAL		3 WEEKS		NONE		NONE	
EDUCATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE	
HIGH SCHOOL		1957		BALTIMORE, MARYLAND		JAMES H. HENRY		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
SIGNED AND SEALED		DATE		PLACE		NAME		TITLE		NAME	
JAMES H. HENRY		1957		BALTIMORE, MARYLAND		JAMES H. HENRY		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. S.

APR 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03915

3914

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD#5</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD#6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Uniontown Road</u>		d. STREET ADDRESS <u>Eastview</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM CLAUTICE HILL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Hill</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Clautice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-14-3126</u>	
17. INFORMANT <u>Margaret W. Hill</u>		Address <u>Westminster Md. RD#6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>3+ yrs</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 54</u> to <u>Apr 20, 1957</u> that I last saw the deceased alive on <u>Apr 12, 1957</u> , and that death occurred at <u>11:30</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Westminster Md.</u> DATE SIGNED <u>4/23/57</u>	
ACTUAL SIGNATURE <u>E. REESE WILKENS</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Run, Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR <u>4-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Muller</u>	

CERTIFICATE OF DEATH

2014

HALLMARK

4/10/14

WILLIAM CHARLIE

James Hill

213-H-10

BUREAU V. S.

APR 24 1957

RECEIVED

3915

CERTIFICATE OF DEATH

03916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uniontown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Uniontown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Hoch</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel W. Carman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Jane Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Rev. John H. Hoch, Uniontown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of ear (left)</u> <u>160x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>21 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 4</u> , 19 <u>57</u> , to <u>April 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>57</u> , and that death occurred at <u>10</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>D. H. Legg</u> M.D. <u>Union Bridge Md 4-8-57</u> PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u> <u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 9, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> ADDRESS <u>Merwyn C. Fuss Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 1957</u>	24b. REGISTRAR'S SIGNATURE <u>A. N. Reduch</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1892		BALTIMORE, MD.	
CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
BALTIMORE		MD.		U.S.A.		APR 10 1957		HOSPITAL		HEART DISEASE	
MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		WIFE	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
APR 10 1957		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

James H. Harris (died)

BUREAU V. S.

APR 10 1957

RECEIVED

James H. Harris
James H. Harris
James H. Harris

DATE	TIME	PLACE	CAUSE
APR 10 1957	10:00 AM	BALTIMORE, MD.	HEART DISEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 19 FilmG213 4-8-57 et

3916

CERTIFICATE OF DEATH

Reg. Dist. No.

03917

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 mos, 23 dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 227 North Curley Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last John Ernest HOWALD				4. DATE OF DEATH Month Day Year April 2 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant		11. BIRTHPLACE (State or foreign country) Switzerland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fritz Howald				14. MOTHER'S MAIDEN NAME Mary Ann --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-03-9175		17. INFORMANT Address Springfield Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombi about infected urinary bladder DUE TO (c) Bronchopneumonia Chronic nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction 20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 9, 1956, to April 2, 1957, that I last saw the deceased alive on April 2, 1957, and that death occurred at 10:50 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walther H. Sonnenfeldt, M.D. Springfield State Hospital 4/3/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/57		22c. NAME OF CEMETERY OR CREMATORY Landon Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Henry Sons				ADDRESS 2024 Orleans St		24a. REC'D BY REGISTRAR DATE 5 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
CITY OF DEATH		COUNTY		STATE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
OCCUPATION OF BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY	
CITY OF DEATH		COUNTY		STATE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
OCCUPATION OF BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY	
CITY OF DEATH		COUNTY		STATE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
OCCUPATION OF BIRTH		CAUSE OF BIRTH		MANNER OF BIRTH	

BUREAU V. S.

APR 5 1957

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Handwritten notes and signatures at the bottom of the form, including dates and names.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to interment, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05047

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 yrs. 7 mos. 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle George Last KLEIN		4. DATE OF DEATH Month April Day 30 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/08
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Workman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Klein		14. MOTHER'S MAIDEN NAME Barbara Welsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO (b) Acute Myocardial infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH minutes months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. 300.3			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-57	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. Harry New		24. REC'D BY REGISTRAR DATE 5/15/57	
		24b. REGISTRAR'S SIGNATURE C. Harry New	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		LOCALITY		HISTORY	
FINDINGS		TESTS		TREATMENT	
SIGNATURE OF EXAMINER		DATE		TIME	
OFFICE		COUNTY		STATE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	
RECEIVED		MAY 15 1957		BUREAU V. 3	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3918

CERTIFICATE OF DEATH

03918

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 10 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			d. STREET ADDRESS 853 Eutaw Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Phoebe Elizabeth Lawson			4. DATE OF DEATH Month Day Year April 25 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-77		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Ruben Cassidy			14. MOTHER'S MAIDEN NAME Catherine J.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS (Chronic brain syndrome) associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6-14 , 19 55 , to 4-25 , 19 57 , that I last saw the deceased alive on 4-25 , 19 57 , and that death occurred at 1:10 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Gertrud Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Unburied	22b. DATE THEREOF 4-29-57	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville		24a. REC'D BY REGISTRAR DATE 4/30/57		24b. REGISTRAR'S SIGNATURE C. Harry Myers	

BUREAU V. 3

MAY 1 1957

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MAY 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03919

82

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Mt. Airy	
		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last LILLY		4. DATE OF DEATH Month April Day 22 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1894
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert E. Lilly		14. MOTHER'S MAIDEN NAME ? Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 215-14-6959	
17. INFORMANT Robert Lilly, Waynesboro, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Several Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1956 to April 1957 , that I last saw the deceased alive on About April 1, 1957 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Culwell		ADDRESS (Street, city or town, state) Mt Airy, Md.	
PHYSICIAN'S NAME (Type) W.B. Culwell		DATE SIGNED 4/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-25-1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Howard Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE 4/26/57		24b. REGISTRAR'S SIGNATURE Edna Hewitt	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOME		APR 26 1957	
DECEASED		SEX	
MALE		AGE	
35		YEARS	
DATE OF BIRTH		PLACE OF BIRTH	
APR 26 1922		BALTIMORE, MARYLAND	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		OCCUPATION	
JAN 15 1945		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
[Signature]		[Address]	
DECEASED'S OCCUPATION		DECEASED'S RELIGION	
LABORER		CATHOLIC	
DECEASED'S RACE		DECEASED'S COLOR	
WHITE		WHITE	
DECEASED'S SEX		DECEASED'S AGE	
MALE		35	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH	
APR 26 1922		BALTIMORE, MARYLAND	
DECEASED'S MARRIAGE		DECEASED'S EDUCATION	
MARRIED		HIGH SCHOOL	
DECEASED'S DATE OF MARRIAGE		DECEASED'S OCCUPATION	
JAN 15 1945		LABORER	
DECEASED'S CAUSE OF DEATH		DECEASED'S MANNER OF DEATH	
HEART DISEASE		NATURAL	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
[Signature]		[Address]	
DECEASED'S OCCUPATION		DECEASED'S RELIGION	
LABORER		CATHOLIC	
DECEASED'S RACE		DECEASED'S COLOR	
WHITE		WHITE	
DECEASED'S SEX		DECEASED'S AGE	
MALE		35	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH	
APR 26 1922		BALTIMORE, MARYLAND	
DECEASED'S MARRIAGE		DECEASED'S EDUCATION	
MARRIED		HIGH SCHOOL	
DECEASED'S DATE OF MARRIAGE		DECEASED'S OCCUPATION	
JAN 15 1945		LABORER	
DECEASED'S CAUSE OF DEATH		DECEASED'S MANNER OF DEATH	
HEART DISEASE		NATURAL	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	

BUREAU V. S.

APR 26 1957

RECEIVED

3920

CERTIFICATE OF DEATH

03920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>4504 Woodlea Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>LITTLE</u> Last <u>LITTLE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 21, 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry - BETZEL</u>				14. MOTHER'S MAIDEN NAME <u>Margaret -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 16, 1957</u> , to <u>April 3, 1957</u> , that I last saw the deceased alive on <u>April 3, 1957</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield Hospital</u> DATE SIGNED <u>4/3/57</u>			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 6, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY BALTIMORE MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WELSH FUNERAL HOME BALTO. MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3921

CERTIFICATE OF DEATH

03921
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11yrs.9mos.24days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 400 Hazlett Avenue			
3. NAME OF DECEASED (Type or print) First William Middle E. Last McCLANAHAN				4. DATE OF DEATH Month April Day 24 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1912		9. AGE (In years lost birthday) 44 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William E. McClanahan				14. MOTHER'S MAIDEN NAME Susie McGuinness			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-acute glomerulonephritis 591x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type. Bronchopneumonia.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 , to April 24, 1957 , that I last saw the deceased alive on April 24, 1957 , and that death occurred at 8:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4/24/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner				ADDRESS Balto		24a. REC'D BY REGISTRAR APR 29 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Lewis			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

NAME OF DECEASED Barry, John		DATE OF DEATH April 29, 1957	
PLACE OF DEATH Boston, Massachusetts		AGE 35 years	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Salesman		RELIGION Roman Catholic	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		DATE April 30, 1957	
SIGNATURE OF REGISTRAR [Signature]		DATE April 30, 1957	

RECEIVED
 APR 29 1957
 BUREAU V. 2

3922

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Carroll</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Manchester</i>	LENGTH OF STAY (in this place) <i>27rs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Seneca</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Longview Convalescent Home</i>		STREET ADDRESS (If rural give location) <i>Seneca</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>FRANKLIN</i>	(Middle) <i>H.</i>	(Last) <i>MILLER</i>	(Month) <i>April</i> (Day) <i>18</i> (Year) <i>1957</i>
5. SEX: <i>Male</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>3/21/78</i>	9. AGE last birthday: <i>79</i> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) <i>Merchant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>General Store</i>	11. BIRTHPLACE (State or foreign country): <i>Adams Co. Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME: <i>Albert Miller</i>		14. MOTHER'S MAIDEN NAME: <i>Jenna Bankert</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		17. INFORMANT & ADDRESS: <i>Ralph Miller Seneca, Md.</i>	
16. SOCIAL SECURITY No.: <i>✓</i>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
Immediate cause (a) <i>Arteriosclerotic Heart Disease</i>				<i>5 yrs</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO				
(c)				
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Dec 1949</i> , to <i>April 18, 1957</i> , that I last saw the deceased alive on <i>April 14 1957</i> , and that death occurred at <i>3:00 AM</i> , from the causes and on the date stated above.				
SIGNATURE <i>W. H. Board</i>		ADDRESS <i>M. D. Manchester MD</i>		DATE SIGNED <i>4/19/57</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>4/21/57</i>	<i>Stone Church</i>	<i>Seneca Pa.</i>	<i>Pa.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<i>Apr. 19-57</i>	<i>Mrs. H. P. Danner</i>	<i>H. Seiple</i>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
3923 Items 2,12 Film G214 5-6-57 et
CERTIFICATE OF DEATH

03923

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY STAMFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINISBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Los Angeles	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CEDARHURST RD.		d. STREET ADDRESS 3319 Military Avenue	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MOORE Last MOORE		4. DATE OF DEATH Month APRIL Day 18 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR: Months 5 Days 9 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GILFIELDS	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HERBERT MOORE		14. MOTHER'S MAIDEN NAME CATHERINE FIELDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 550-09-3765	
17. INFORMANT MRS. L. B. SPENCER		Address FINISBURG, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma mandib. Met. 196x DUE TO 2 x lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1957, to Apr 18 1957, that I last saw the deceased alive on Apr 18 1957, and that death occurred at 11:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm C. Jennette M.D.		ADDRESS (Street, city or town, state) 103 E Main Westminster MD DATE SIGNED 4-20-57	
PHYSICIAN'S NAME (Type) Wm Carl Jennette		ADDRESS 103 E Main Westminster MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-21-57	
22c. NAME OF CEMETERY OR CREMATORY METHODIST CEM. FINISBURG MD		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard		ADDRESS Westminster MD	
24a. REC'D BY REGISTRAR DATE 4-24-57		24b. REGISTRAR'S SIGNATURE H. C. Miller	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 23 1937

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3924

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair 12322			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 15 Lee Street			
3. NAME OF DECEASED (Type or print) First Ellsworth Middle Westley Last Moore				4. DATE OF DEATH Month April Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 8, 1895 66 yrs.	
9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mark Moore				14. MOTHER'S MAIDEN NAME Isabella Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-14-3270		17. INFORMANT Ellsworth W. Moore - 15 Lee Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular disease DUE TO (b) Syphilis or Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pulmonary Tuberculosis, far advanced (c) Pulmonary Tuberculosis, far advanced							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 12, 1957 , to April 20, 1957 , that I last saw the deceased alive on April 20, 1957 , and that death occurred at 12:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE T. F. Vestal				ADDRESS (Street, city or town, state) Henryton, Maryland			
DATE SIGNED 4-19-57				M.D.			
PHYSICIAN'S NAME (Type) T. F. Vestal, Superintendent				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/23/57		22c. NAME OF CEMETERY OR CREMATORY Tabernacle Cemetery		22d. LOCATION (City, town, or county) (State) Benson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Barker W. W. B.				24a. REC'D BY REGISTRAR 556-222-30		24b. REGISTRAR'S SIGNATURE Albert R. Swankhaus	
DATE 4-22-57							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03925

CERTIFICATE OF DEATH

Reg. Dist. No. 74

3925

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>since 3-5-56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro 21x12</u>	
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>Elias</u> Last <u>MOSER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 12, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer and wood worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Ezra Moser</u>		14. MOTHER'S MAIDEN NAME <u>Roseann Itnyre</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records of Springfield State Hospital</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC LOBAR Pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>Morbid dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>over 10 y.</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. prob. a. senile brain disease c. pyelonephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) <u>---</u> (County) (State)	
21. I certify that I attended the deceased from <u>March 5th</u> , 19 <u>56</u> , to <u>April 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>57</u> , and that death occurred at <u>5:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Martin Gross</u> M.D. <u>Springfield State Hospital</u> <u>4-23-57</u>			
PHYSICIAN'S NAME (Type) <u>Martin Gross, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL-25 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRNEYS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NR. MAPLEVILLE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME BOONSBORO MARYLAND</u>		24a. REC'D BY REGISTRAR <u>4/24/57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Weaver</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. DATE OF DEATH [Faint text]</p>		<p>10. PLACE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. 3

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3926

CERTIFICATE OF DEATH

Reg. Dist. No.

03926

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7 mos, 17 dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Spencerville 15x12			
3. NAME OF DECEASED (Type or print) First Hanley Middle James Last MULLIN				4. DATE OF DEATH Month April Day 9, Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1885		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY GEN. BLDG TRAVEL		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Mullin				14. MOTHER'S MAIDEN NAME Martha Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-26-4274		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 INDEX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 903.7 (b) Decubitous ulcer DUE TO (c) psychotic reaction							INTERVAL BETWEEN ONSET AND DEATH years weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right hip. CBS assoc. with cerebral arteriosclerosis with							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Slipped and fell as he stepped from shower in bathroom.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 5:45 p. m. Month 3 Day 6 Year 57				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital ward	
20f. (City or town) Sykesville				20g. (County) Carroll		20h. (State) Md.	
21. I certify that I attended the deceased from August 22, 1956 , to April 9, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				DATE SIGNED 4/9/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR 11, 1957		22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEM		22d. LOCATION (City, town, or county) (State) RICES RD HYATTSVILLE, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Staller				24a. REC'D BY REGISTRAR DATE 11 1957		24b. REGISTRAR'S SIGNATURE C. Harry Hoops	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. MEDICAL HISTORY [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]	
11. SIGNATURE OF DECEASED [Illegible]		12. SIGNATURE OF WITNESS [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF WITNESS [Illegible]	
17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF WITNESS [Illegible]	
21. SIGNATURE OF DECEASED [Illegible]		22. SIGNATURE OF WITNESS [Illegible]	
23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF WITNESS [Illegible]	
27. SIGNATURE OF DECEASED [Illegible]		28. SIGNATURE OF WITNESS [Illegible]	
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31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF WITNESS [Illegible]	
33. SIGNATURE OF DECEASED [Illegible]		34. SIGNATURE OF WITNESS [Illegible]	
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41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF WITNESS [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF WITNESS [Illegible]	
45. SIGNATURE OF DECEASED [Illegible]		46. SIGNATURE OF WITNESS [Illegible]	
47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF WITNESS [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF WITNESS [Illegible]	
51. SIGNATURE OF DECEASED [Illegible]		52. SIGNATURE OF WITNESS [Illegible]	
53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF WITNESS [Illegible]	
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57. SIGNATURE OF DECEASED [Illegible]		58. SIGNATURE OF WITNESS [Illegible]	
59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF WITNESS [Illegible]	
63. SIGNATURE OF DECEASED [Illegible]		64. SIGNATURE OF WITNESS [Illegible]	
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67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF WITNESS [Illegible]	
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71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF WITNESS [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF WITNESS [Illegible]	
75. SIGNATURE OF DECEASED [Illegible]		76. SIGNATURE OF WITNESS [Illegible]	
77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF WITNESS [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF WITNESS [Illegible]	
81. SIGNATURE OF DECEASED [Illegible]		82. SIGNATURE OF WITNESS [Illegible]	
83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF WITNESS [Illegible]	
87. SIGNATURE OF DECEASED [Illegible]		88. SIGNATURE OF WITNESS [Illegible]	
89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF WITNESS [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF WITNESS [Illegible]	
93. SIGNATURE OF DECEASED [Illegible]		94. SIGNATURE OF WITNESS [Illegible]	
95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF WITNESS [Illegible]	
99. SIGNATURE OF DECEASED [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

APR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3927

CERTIFICATE OF DEATH

Reg. Dist. No.

03927

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 38yr, 8mo, 11dy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 9 East Lafayette Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last MUTH		4. DATE OF DEATH Month April 18, Day 19 Year 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traveling Saleslady		10b. KIND OF BUSINESS OR INDUSTRY stove company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Muth		14. MOTHER'S MAIDEN NAME Sallie R. Tracey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -444	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, minimal, active DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type. Diabetes.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 , to April 18, 1957 , that I last saw the deceased alive on April 18, 1957 , and that death occurred at 3:00P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund B. Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/18/57	
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-57	
22c. NAME OF CEMETERY OR CREMATORY Bosley Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR 4-19-57		24b. REGISTRAR'S SIGNATURE C. Harry Baker	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922		5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School		11. PRESENT ADDRESS Room 303, 440 North Dearborn St., Chicago, Ill.		12. DATE OF DEATH April 4, 1968	
13. CAUSE OF DEATH Suicide by gunshot		14. MANNER OF DEATH Homicide		15. PLACE OF DEATH Chicago, Illinois		16. TIME OF DEATH 11:00 AM		17. SIGNATURE OF DECEASED None		18. SIGNATURE OF WITNESS None	
19. SIGNATURE OF PHYSICIAN None		20. SIGNATURE OF CORONER None		21. SIGNATURE OF JURY None		22. SIGNATURE OF STATE ATTORNEY None		23. SIGNATURE OF DISTRICT ATTORNEY None		24. SIGNATURE OF CLERK None	

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APR 23 1968
BUREAU V. 2

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3928

CERTIFICATE OF DEATH

Reg. Dist. No.

0392874

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Glen Wood 13x02</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>ALBERT</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Myers</u>				14. MOTHER'S MAIDEN NAME <u>Julia Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-22-0276</u>			
				17. INFORMANT <u>Lena Myers -</u> Address <u>Cuthnersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL Arrest, Coronary Thrombosis,</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arricular fibrillation, Atherosclerosis,</u> DUE TO (c) <u>Hypertension, Obesity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Jan 57</u> <u>April 57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>11 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 April</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P. M.</u> from the causes and an the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED <u>11 April 57</u>			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/15/57</u>		<u>Bush Park,</u>		<u>Cookesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sander</u> ADDRESS <u>Cookesville, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Jones</u>	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

BUREAU V. 3

APR 18 1957

RECEIVED

3929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R.D.1 (Silver Run)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster x2 d. STREET ADDRESS Westminster, Md. R.D.1 (Silver Run) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jacob David Petry				4. DATE OF DEATH Month April Day 15 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY His own farm		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph G. Petry				14. MOTHER'S MAIDEN NAME Catherine Starnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-2469		17. INFORMANT Chester A. Petry Address Chester A. Petry, R.D.1, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 592x DUE TO Myocardial (old) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (old) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May, 1952 , to April 15, 1957 , that I last saw the deceased alive on April 13, 1957 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Bennett		ADDRESS (Street, city or town, state) DATE SIGNED 10315 Main Westminster Md 4-16-57					
PHYSICIAN'S NAME (Type) W. C. Bennett MD		Westminster Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 18, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	24a. REC'D BY REGISTRAR DATE 4-16-57	24b. REGISTRAR'S SIGNATURE Harriet Muller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1957

RECEIVED

3930

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 12 yrs, 5 dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Lonaconing 01X22			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jacob Middle William Last Reichelt				4. DATE OF DEATH Month April Day 16 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1899		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass blower		10b. KIND OF BUSINESS OR INDUSTRY Glass Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolph Reichelt				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilis of the central nervous system DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with syphilitic meningo-encephalitis. Cirrhosis of the liver.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 , to April 16, 1957 , that I last saw the deceased alive on April 16, 1957 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/17/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-17-57		22c. NAME OF CEMETERY OR CREMATORY Good Hope School		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walther H. Sonnenfeldt				ADDRESS		24a. REC'D BY REGISTRAR DATE 4-18-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Hays			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1912		Maryland		Farmer		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
April 22, 1957		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. DISTRICT		22. WARD		23. BLOCK		24. LOT	
Baltimore		Baltimore		Maryland		21201		1st		1st		1st		1st	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF SURVIVOR		28. SIGNATURE OF BURIAL OFFICIAL		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF REVIEWER	

BUREAU V. S.

APR 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03931

3931

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos, 15 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 4501 Cortland Road	
3. NAME OF DECEASED (Type or print) First Charles Middle Edwin Last ROSE		4. DATE OF DEATH Month April Day 12 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1921
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - Yuk	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin J. Rose		14. MOTHER'S MAIDEN NAME Ruth DeFrehm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yuk	
17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute interstitial pneumonitis, right lung 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute collapse of the right lung DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH days day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with congenital spastic paraplegia with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 19 56 , to April 12, 19 57 , that I lost the deceased alive on April 12, 19 57 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/12/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-15-57	22c. NAME OF CEMETERY OR CREMATORY Grand View	22d. LOCATION (City, town, or county) (State) Johnstown Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight - Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 4-14-57 24b. REGISTRAR'S SIGNATURE C. Henry Allen	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 5

RECEIVED

3932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 9 months 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				d. STREET ADDRESS 717 W. 36th. st. Baltimore 11			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Charles Middle Jacob Last Sieck		4. DATE OF DEATH		Month 4 Day 27 Year 1957	
5. SEX Male White	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-91	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eugene Sieck				14. MOTHER'S MAIDEN NAME Georana McBunnin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-01-3377		17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic heart disease.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome with C.A.S. without qualifying phrase							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-29- 1956 , to 4-27- 1957 , that I last saw the deceased alive on 4-27- 1957 , and that death occurred at 11.50p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital.		DATE SIGNED 4-28-57	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-57		22c. NAME OF CEMETERY OR CREMATORY Wm. Cemetery		22d. LOCATION (City, town, or county) (State) Dallastown Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Seitz ADDRESS 814 W 36th St				24a. REC'D BY REGISTRAR 4/30/57		24b. REGISTRAR'S SIGNATURE C. Harry Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 18

Name of Deceased		Last Name		First Name		Middle Name	
George Washington		Washington		George		Washington	
Date of Birth		Month		Day		Year	
July 28-07		July		28		1907	
Place of Birth		County		State		Country	
St. Louis, Mo.		St. Louis		Mo.		U.S.A.	
Date of Death		Month		Day		Year	
July 28-07		July		28		1907	
Place of Death		County		State		Country	
St. Louis, Mo.		St. Louis		Mo.		U.S.A.	
Cause of Death		Immediate		Underlying		Contributing	
Typhoid fever		Typhoid fever		Typhoid fever		Typhoid fever	
Duration of Illness		Days		Weeks		Months	
10		2		0		0	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU Y. S.

MAY 1 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03933

3933

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Smith				4. DATE OF DEATH Month Day Year April 2 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-81	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? — Feeheley				14. MOTHER'S MAIDEN NAME NOT KNOWN MARY HAMMELMANN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction						INTERVAL BETWEEN ONSET AND DEATH 2 weeks plus Years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-14 , 19 53 , to 4-2 , 19 57 , that I last saw the deceased alive on 4-2 , 19 57 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrud Souwenfeldt M.D. Springfield State Hospital Sykesville Md				DATE SIGNED 4/2/57			
PHYSICIAN'S NAME (Type) Gertrud Souwenfeldt M.D. Springfield State Hospital Sykesville Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/5/57		22c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wanner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE Apr. 8, 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Edew			

3934
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard 151	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr.4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Huseby Last Sorflaten		4. DATE OF DEATH Month 4- Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-1878
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Yunk	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arne A. Huseby		14. MOTHER'S MAIDEN NAME Syneva Huseby-nee Hukee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Yunk	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 904.7 (b) Generalized arteriosclerosis DUE TO (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involutional Psychotic reaction. Fracture rt. Femur. Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) She said to have fallen on the floor	
20c. TIME OF INJURY Month, Day, Year Hour a. p. Unknown 2-27-1957		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> Hospital	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sykesville		20f. (City or town) (County) (State) Carroll Md.	
21. I certify that I attended the deceased from 11-15- 19 55 , to 4-13- 19 57 , that I last saw the deceased alive on 4-13- 19 57 , and that death occurred at 5.30p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		DATE SIGNED 4-14-57	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		Sykesville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-18-57	22c. NAME OF CEMETERY OR CREMATORY Little Cedar Lutheran	22d. LOCATION (City, town, or county) (State) Adams, Minn.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight - Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 4-15-57	
		24b. REGISTRAR'S SIGNATURE C. Harry Egan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MOTHER'S MARRIAGE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		BUSINESS MAN		BUSINESS MAN		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		HISTORY OF DEATH		HISTORY OF DEATH	
APR 4 1968		MEMPHIS, TENN		HEART DISEASE		SUICIDE		2 WEEKS		NONE		HEART DISEASE		HEART DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		HISTORY OF DEATH		HISTORY OF DEATH	
APR 4 1968		MEMPHIS, TENN		HEART DISEASE		SUICIDE		2 WEEKS		NONE		HEART DISEASE		HEART DISEASE	

BUREAU V. S.

APR 18 1968

RECEIVED

3935 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. 4 Reese		e. STREET ADDRESS 1 R. 4 Reese	
3. NAME OF DECEASED (Type or print) First Florence Middle Ann Last Sprinkle		4. DATE OF DEATH Month April Day 5 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John H. Taylor	
14. MOTHER'S MAIDEN NAME Margaretta Magee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Carroll Taylor Carrollton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of lungs 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic myocarditis DUE TO (c) acute respiratory infection			INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-2 , 19 57 , to 4-5 , 19 57 , that I last saw the deceased alive on 4-4 , 19 57 , and that death occurred at 4 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. L. Billingslea M.D.		ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 4-5-57	
PHYSICIAN'S NAME (Type) C. L. Billingslea, M.D.		1 S. South Center St. Westminster,	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-7-1957	22c. NAME OF CEMETERY OR CREMATORY Carrollton Church of God	22d. LOCATION (City, town, or county) (State) Carrollton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR DATE 4-8-57		24b. REGISTRAR'S SIGNATURE Harriet Miller	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3936

CERTIFICATE OF DEATH

03936

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1 yr., 4 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Laurel</u> 13x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Gorman Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lilly May Stanowsky</u>				4. DATE OF DEATH Month Day Year <u>April 9 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-74</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Money counter--U.S. Treas.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Bell</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Years _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with senile brain disease with psychotic reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-25</u> , 19 <u>55</u> , to <u>4-9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>57</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrud Sonnenfeldt</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>4/9/57</u>	
PHYSICIAN'S NAME (Type) <u>Gertrud Sonnenfeldt</u>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dry Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Donaldson, Laurel, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES J. JONES		M		35		1922		NEW YORK		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
APR 18 1957		10:00 PM		HOME		HEART DISEASE		NATURAL		J. J. JONES		J. J. JONES		J. J. JONES	
17. NAME OF FUNERAL HOME		18. NAME OF FUNERAL HOME		19. NAME OF FUNERAL HOME		20. NAME OF FUNERAL HOME		21. NAME OF FUNERAL HOME		22. NAME OF FUNERAL HOME		23. NAME OF FUNERAL HOME		24. NAME OF FUNERAL HOME	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. S.

APR 18 1957

RECEIVED

3880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
c. LENGTH OF STAY IN 1b Life				27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 59 Carroll St.				d. STREET ADDRESS 59 Carroll St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carroll Middle King Last Stouch				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Painter		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Painter		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Stouch				14. MOTHER'S MAIDEN NAME Rebecca Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-14-7986		17. INFORMANT Address Mrs. Stella H. Stouch Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Atherosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/5 , 19 57 , to 4/5 , 19 57 , that I last saw the deceased alive on 4/5 , 19 57 , and that death occurred at 10:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Shute Bare				DATE SIGNED Westminster Maryland 4/6/57			
PHYSICIAN'S NAME (Type) S. Luther Bare, M.D.				79 W. Main St. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 57		22c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery		22d. LOCATION (City, town, or county) (State) nr Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 11-8-57	
				24b. REGISTRAR'S SIGNATURE Harriet Butler			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF PHYSICIAN		NAME OF NURSE	
NAME OF CORONER		NAME OF JURY	
NAME OF WITNESSES		NAME OF OFFICIALS	
NAME OF REGISTRAR		NAME OF CLERK	
NAME OF ASSISTANT CLERK		NAME OF RECEPTIONIST	
NAME OF TELEPHONE OPERATOR		NAME OF MAIL CLERK	
NAME OF RECORDS CLERK		NAME OF INDEX CLERK	
NAME OF FILE CLERK		NAME OF DISTRIBUTION CLERK	
NAME OF COLLECTION CLERK		NAME OF ACCOUNT CLERK	
NAME OF PURCHASE CLERK		NAME OF SALE CLERK	
NAME OF DELIVERY CLERK		NAME OF RECEIPT CLERK	
NAME OF RETURN CLERK		NAME OF CANCELLATION CLERK	
NAME OF RE-ENTRY CLERK		NAME OF DEPORTATION CLERK	
NAME OF INSPECTION CLERK		NAME OF ADJUDICATION CLERK	
NAME OF APPEAL CLERK		NAME OF REVIEW CLERK	
NAME OF FINAL CLERK		NAME OF CLOSING CLERK	

BUREAU V. 2

APR 10 1957

RECEIVED

3881

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>18 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>99 E. MAIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET CATHERINE SWARTZBAUGH</u>		4. DATE OF DEATH <u>APRIL 10 1957</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 11-1919</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>WILLIAM H. BLESSING</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE SCHUCHART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21-12-1012</u>	
17. INFORMANT <u>CARROLL O. SWARTZBAUGH</u>		Address <u>99 E MAIN WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Right Breast</u> DUE TO <u>metastases to spine</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Anemia & Cachexia</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>April 10, 1957</u> that I last saw the deceased alive on <u>April 9, 1957</u> and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>4/11/57</u>	
ACTUAL SIGNATURE <u>William Speicher</u>		PHYSICIAN'S NAME (Type) <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-13-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>FINESBORG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bamford Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>4-16-57</u> 24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1967

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		1-12-1932		MOBILE, ALABAMA		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		PRACTICING LAWYER		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
1-14-1968		MOBILE, ALABAMA		ALABAMA		UNITED STATES		UNITED STATES		1-14-1968		MOBILE, ALABAMA		ALABAMA	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF OTHER	

BUREAU V. 3

PR 48 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03939

3937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural Taneytown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Roop Teeter</u>				4. DATE OF DEATH Month Day Year <u>April 15, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Roop</u>				14. MOTHER'S MAIDEN NAME <u>Celia Utz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Robert C. Clingan, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Few min.</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 26</u> , 19 <u>45</u> , to <u>April 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>R. A. McVaugh</u> M.D. <u>49 Frederick Street-Taneytown, Md.</u> PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Windsor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> ADDRESS <u>Taneytown, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN	
19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF HEALTH DEPARTMENT		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF DISTRICT ATTORNEY		26. SIGNATURE OF SHERIFF		27. SIGNATURE OF TOWNSHIP CLERK	
28. SIGNATURE OF VOTING CLERK		29. SIGNATURE OF SCHOOL CLERK		30. SIGNATURE OF CHURCH CLERK	
31. SIGNATURE OF POST OFFICE CLERK		32. SIGNATURE OF RAILROAD CLERK		33. SIGNATURE OF AIRPORT CLERK	
34. SIGNATURE OF MARINE CLERK		35. SIGNATURE OF NAVY CLERK		36. SIGNATURE OF ARMY CLERK	
37. SIGNATURE OF AIR FORCE CLERK		38. SIGNATURE OF SPACE CLERK		39. SIGNATURE OF DEFENSE CLERK	
40. SIGNATURE OF INTELLIGENCE CLERK		41. SIGNATURE OF INFORMATION CLERK		42. SIGNATURE OF RECORDS CLERK	
43. SIGNATURE OF COMMUNICATIONS CLERK		44. SIGNATURE OF TRANSPORTATION CLERK		45. SIGNATURE OF SUPPLY CLERK	
46. SIGNATURE OF FINANCE CLERK		47. SIGNATURE OF PERSONNEL CLERK		48. SIGNATURE OF TRAINING CLERK	
49. SIGNATURE OF EQUIPMENT CLERK		50. SIGNATURE OF MAINTENANCE CLERK		51. SIGNATURE OF LOGISTICS CLERK	
52. SIGNATURE OF POLICE CLERK		53. SIGNATURE OF FIRE DEPARTMENT CLERK		54. SIGNATURE OF PUBLIC WORKS CLERK	
55. SIGNATURE OF SANITATION CLERK		56. SIGNATURE OF HEALTH DEPARTMENT CLERK		57. SIGNATURE OF SOCIAL SERVICES CLERK	
58. SIGNATURE OF EDUCATION CLERK		59. SIGNATURE OF LABOR RELATIONS CLERK		60. SIGNATURE OF INDUSTRIAL RELATIONS CLERK	
61. SIGNATURE OF AGRICULTURE CLERK		62. SIGNATURE OF COMMERCE CLERK		63. SIGNATURE OF ENERGY CLERK	
64. SIGNATURE OF ENVIRONMENTAL CLERK		65. SIGNATURE OF HOUSING CLERK		66. SIGNATURE OF TRANSPORTATION CLERK	
67. SIGNATURE OF INFRASTRUCTURE CLERK		68. SIGNATURE OF PUBLIC SAFETY CLERK		69. SIGNATURE OF COMMUNITY DEVELOPMENT CLERK	
70. SIGNATURE OF ECONOMIC DEVELOPMENT CLERK		71. SIGNATURE OF TOURISM CLERK		72. SIGNATURE OF CULTURAL AFFAIRS CLERK	
73. SIGNATURE OF RELIGION CLERK		74. SIGNATURE OF ARTS CLERK		75. SIGNATURE OF RECREATION CLERK	
76. SIGNATURE OF PARKS CLERK		77. SIGNATURE OF CONSERVATION CLERK		78. SIGNATURE OF HISTORIC PRESERVATION CLERK	
79. SIGNATURE OF ARCHITECTURE CLERK		80. SIGNATURE OF ENGINEERING CLERK		81. SIGNATURE OF PLANNING CLERK	
82. SIGNATURE OF ZONING CLERK		83. SIGNATURE OF LAND USE CLERK		84. SIGNATURE OF TRANSPORTATION CLERK	
85. SIGNATURE OF INFRASTRUCTURE CLERK		86. SIGNATURE OF PUBLIC SAFETY CLERK		87. SIGNATURE OF COMMUNITY DEVELOPMENT CLERK	
88. SIGNATURE OF ECONOMIC DEVELOPMENT CLERK		89. SIGNATURE OF TOURISM CLERK		90. SIGNATURE OF CULTURAL AFFAIRS CLERK	
91. SIGNATURE OF RELIGION CLERK		92. SIGNATURE OF ARTS CLERK		93. SIGNATURE OF RECREATION CLERK	
94. SIGNATURE OF PARKS CLERK		95. SIGNATURE OF CONSERVATION CLERK		96. SIGNATURE OF HISTORIC PRESERVATION CLERK	
97. SIGNATURE OF ARCHITECTURE CLERK		98. SIGNATURE OF ENGINEERING CLERK		99. SIGNATURE OF PLANNING CLERK	
100. SIGNATURE OF ZONING CLERK		101. SIGNATURE OF LAND USE CLERK		102. SIGNATURE OF TRANSPORTATION CLERK	

RECEIVED
APR 17 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03940

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedarhurst		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cedarhurst			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) Dorothy Grace Trump				4. DATE OF DEATH Month April Day 30 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1926	9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Walter F. Sullivan				14. MOTHER'S MAIDEN NAME Ruth E. Bair			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence C. Trump, Cedarhurst, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion (Acute) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none Obesity 420.1							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none			
20f. (City or town) none		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>James T. Marsh</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh, M. D.				DATE SIGNED 5-1-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4/57		22c. NAME OF CEMETERY OR CREMATORY Finksburg			
22d. LOCATION (City, town, or county) Finksburg, Md.		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 5-2-57			
24b. REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. B.

MAY 6 1957

RECEIVED

3939

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Barnes</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>W</u> Middle <u>Wrey</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Wrey</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Minker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Miss M Halland</u> Address <u>Hampstead</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerotic C-V Disease</u> DUE TO (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>April 4, 1957</u> , that I last saw the deceased alive on <u>April 4, 1957</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>		DATE SIGNED <u>4-4-57</u>	
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.			
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		<u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Apr 7-1957</u>	<u>McKendree</u>	<u>Arville Rd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Chpton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Apr 6/57</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. H.P. Lerner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
22. SIGNATURE OF INTERVIEWER'S SUPERVISOR		23. SIGNATURE OF INTERVIEWER'S SUPERVISOR		24. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
25. SIGNATURE OF INTERVIEWER'S SUPERVISOR		26. SIGNATURE OF INTERVIEWER'S SUPERVISOR		27. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
28. SIGNATURE OF INTERVIEWER'S SUPERVISOR		29. SIGNATURE OF INTERVIEWER'S SUPERVISOR		30. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
31. SIGNATURE OF INTERVIEWER'S SUPERVISOR		32. SIGNATURE OF INTERVIEWER'S SUPERVISOR		33. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
34. SIGNATURE OF INTERVIEWER'S SUPERVISOR		35. SIGNATURE OF INTERVIEWER'S SUPERVISOR		36. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
37. SIGNATURE OF INTERVIEWER'S SUPERVISOR		38. SIGNATURE OF INTERVIEWER'S SUPERVISOR		39. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
40. SIGNATURE OF INTERVIEWER'S SUPERVISOR		41. SIGNATURE OF INTERVIEWER'S SUPERVISOR		42. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
43. SIGNATURE OF INTERVIEWER'S SUPERVISOR		44. SIGNATURE OF INTERVIEWER'S SUPERVISOR		45. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
46. SIGNATURE OF INTERVIEWER'S SUPERVISOR		47. SIGNATURE OF INTERVIEWER'S SUPERVISOR		48. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
49. SIGNATURE OF INTERVIEWER'S SUPERVISOR		50. SIGNATURE OF INTERVIEWER'S SUPERVISOR		51. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
52. SIGNATURE OF INTERVIEWER'S SUPERVISOR		53. SIGNATURE OF INTERVIEWER'S SUPERVISOR		54. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
55. SIGNATURE OF INTERVIEWER'S SUPERVISOR		56. SIGNATURE OF INTERVIEWER'S SUPERVISOR		57. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
58. SIGNATURE OF INTERVIEWER'S SUPERVISOR		59. SIGNATURE OF INTERVIEWER'S SUPERVISOR		60. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
61. SIGNATURE OF INTERVIEWER'S SUPERVISOR		62. SIGNATURE OF INTERVIEWER'S SUPERVISOR		63. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
64. SIGNATURE OF INTERVIEWER'S SUPERVISOR		65. SIGNATURE OF INTERVIEWER'S SUPERVISOR		66. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
67. SIGNATURE OF INTERVIEWER'S SUPERVISOR		68. SIGNATURE OF INTERVIEWER'S SUPERVISOR		69. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
70. SIGNATURE OF INTERVIEWER'S SUPERVISOR		71. SIGNATURE OF INTERVIEWER'S SUPERVISOR		72. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
73. SIGNATURE OF INTERVIEWER'S SUPERVISOR		74. SIGNATURE OF INTERVIEWER'S SUPERVISOR		75. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
76. SIGNATURE OF INTERVIEWER'S SUPERVISOR		77. SIGNATURE OF INTERVIEWER'S SUPERVISOR		78. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
79. SIGNATURE OF INTERVIEWER'S SUPERVISOR		80. SIGNATURE OF INTERVIEWER'S SUPERVISOR		81. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
82. SIGNATURE OF INTERVIEWER'S SUPERVISOR		83. SIGNATURE OF INTERVIEWER'S SUPERVISOR		84. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
85. SIGNATURE OF INTERVIEWER'S SUPERVISOR		86. SIGNATURE OF INTERVIEWER'S SUPERVISOR		87. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
88. SIGNATURE OF INTERVIEWER'S SUPERVISOR		89. SIGNATURE OF INTERVIEWER'S SUPERVISOR		90. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
91. SIGNATURE OF INTERVIEWER'S SUPERVISOR		92. SIGNATURE OF INTERVIEWER'S SUPERVISOR		93. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
94. SIGNATURE OF INTERVIEWER'S SUPERVISOR		95. SIGNATURE OF INTERVIEWER'S SUPERVISOR		96. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
97. SIGNATURE OF INTERVIEWER'S SUPERVISOR		98. SIGNATURE OF INTERVIEWER'S SUPERVISOR		99. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
100. SIGNATURE OF INTERVIEWER'S SUPERVISOR		101. SIGNATURE OF INTERVIEWER'S SUPERVISOR		102. SIGNATURE OF INTERVIEWER'S SUPERVISOR	

RECEIVED
BUREAU V. S.
APR 11 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03942

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOUNTAIN VALLEY				d. STREET ADDRESS FOUNTAIN VALLEY			
3. NAME OF DECEASED (Type or print) First Middle Last EFFIE JANE WANTZ				4. DATE OF DEATH Month Day Year APRIL 30 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 28, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MICHAEL WASHINGTON MYERS				14. MOTHER'S MAIDEN NAME MARY JANE BLACK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. POT BASSER WESTMINSTER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUFFOCATION - BY HANGING 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HANGED SELF					
20c. TIME OF INJURY Month, Day, Year Hour 11 p.m. 4-30 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) WESTMINSTER		(County) CARROLL		(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES T. MARSH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 4, 1957		22c. NAME OF CEMETERY OR CREMATORY RIPPER'S CEMETERY		22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS David C. Bankard Westminster, Md.				24a. REC'D BY REGISTRAR DATE 5-4-57		24b. REGISTRAR'S SIGNATURE Homer Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF JURY		19. SIGNATURE OF CORONER		20. SIGNATURE OF CLERK	

BUREAU V. 2

MAY 6 1957

RECEIVED

3941

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>		c. LENGTH OF STAY IN 1b <u>70 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER X2</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GRACE</u> First <u>MAY</u> Middle <u>WARD</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 20/1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES HATFIELD</u>				14. MOTHER'S MAIDEN NAME <u>JULIA HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>42-23624</u>		17. INFORMANT Address <u>JOHN V. WARD MANCHESTER, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>52</u> , to <u>April 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>57</u> , and that death occurred at <u>1:40 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MANCHESTER, MD.</u> DATE SIGNED <u>4/17/57</u> ACTUAL SIGNATURE <u>W. H. Foard</u> PHYSICIAN'S NAME (Type) <u>W. H. FOARD, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/18/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF BRETHREN SAMSLER</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Bankard Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harold V. Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03944

3942

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Theodore Middle W. Last Welk				4. DATE OF DEATH Month April Day 24 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1872		9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Welk				14. MOTHER'S MAIDEN NAME Savilla Starner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Clarence E. Welk, Westminster, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Arterio Sclerotic Cardio Renal (c) disease & myocardial degeneration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 19 57 , to April 24, 19 57 , that I last saw the deceased alive on April 23, 19 57 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, State) Westminster, Maryland DATE SIGNED 4/25/57							
ACTUAL SIGNATURE Merwyn C. Fuss		PHYSICIAN'S NAME (Type) Merwyn C. Fuss					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) (State) Pleasant Valley, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss				ADDRESS Tanewtown, Maryland		24a. REC'D BY REGISTRAR 4/26/57	
				24b. REGISTRAR'S SIGNATURE Harriet Mullis			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. BIRTH DATE [Faint text]		6. BIRTH PLACE [Faint text]		7. MARRIAGE DATE [Faint text]		8. MARRIAGE PLACE [Faint text]	
9. OCCUPATION [Faint text]		10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. PLACE OF DEATH [Faint text]		13. TIME OF DEATH [Faint text]		14. DATE OF DEATH [Faint text]		15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF WITNESS [Faint text]	
17. SIGNATURE OF PHYSICIAN [Faint text]		18. SIGNATURE OF CLERK [Faint text]		19. SIGNATURE OF JUDGE [Faint text]		20. SIGNATURE OF SHERIFF [Faint text]		21. SIGNATURE OF CORONER [Faint text]		22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF PHYSICIAN [Faint text]	

BUREAU V. S.

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3943

CERTIFICATE OF DEATH

03945
26

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD 5</u>				d. STREET ADDRESS <u>RD. 5</u>			
3. NAME OF DECEASED (Type or print) <u>EDGAR M. C. KAY WILHELM</u>				4. DATE OF DEATH <u>APRIL 12 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 5-1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Far</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MATTHEW H. WILHELM</u>				14. MOTHER'S MAIDEN NAME <u>MARTELLEN FOREMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>ELLEN DALEY</u> Address <u>RD 5 WESTMINSTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive intestinal hemorrhage</u> DUE TO <u>cancer of bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>about 6 mos.</u> (c) <u>about 6 mos.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 15, 1957</u> to <u>Apr 12, 1957</u> that I last saw the deceased alive on <u>Apr 12, 1957</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. Reese Wilkens</u>				ADDRESS (Street, city or town, state) <u>15 Keen Westminister</u>			
PHYSICIAN'S NAME (Type) <u>D. REESE WILKENS</u>				DATE SIGNED <u>4/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 16 1957</u>		22c. NAME OF GEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u> ADDRESS <u>Westminister Md</u>				24a. REC'D BY REGISTRAR <u>DATE 4-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

BUREAU V. S.

APR 18 1957

RECEIVED

3944

CERTIFICATE OF DEATH

03946

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>9 1/2 yrs</u>				d. STREET ADDRESS <u>1 Main St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Evans</u> Last <u>Walson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May (?) 1855</u>	
9. AGE (In years lost/birthday) <u>101</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Varden Evans</u>				14. MOTHER'S MAIDEN NAME <u>Emily J. Dodson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Self.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>Dec 28</u> , 19 <u>47</u> , to <u>April 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 26</u> , 19 <u>57</u> , and that death occurred at <u>11:15</u> M., from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>		DATE SIGNED <u>4/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons - Balt. 17, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>4-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. H. R. Schenck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. DATE OF DEATH [Faint handwritten date]</p>	
<p>11. PLACE OF DEATH [Faint handwritten place]</p>		<p>12. SIGNATURE OF DECEASED [Faint handwritten signature]</p>	
<p>13. SIGNATURE OF WITNESSES [Faint handwritten signatures]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>15. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>16. OFFICIAL SEAL [Faint official seal]</p>	

BUREAU V. 2

MAY 1 1957

RECEIVED

3945

CERTIFICATE OF DEATH

03947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>6 YRS.</u>		d. STREET ADDRESS <u>R.D. 6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD 6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VIRGIE</u> First <u>LENNIE</u> Middle <u>ZEPP</u> Last		4. DATE OF DEATH <u>APRIL 20</u> Month <u>1957</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 18, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE G. STEM</u>		14. MOTHER'S MAIDEN NAME <u>IDA MAY POOLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MELVIN F. ZEPP WESTMINSTER, MD.</u>	
17. INFORMANT <u>RD 6</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1930</u> , to <u>Apr 20 - 1957</u> , that I last saw the deceased alive on <u>Apr 20 - 1957</u> , and that death occurred on <u>May 1957</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Jernette</u>		DATE SIGNED <u>103 E Main Westminster Md 4-22-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm Earl Jernette MD</u>		ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-23-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ZION CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>RD 6 WESTMINSTER, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster Md</u>		24a. REC'D BY REGISTRAR <u>DATE 4-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1-1-57

1. NAME OF DECEASED JOHN J. JONES		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 11-15-1911		5. PLACE OF BIRTH NEW YORK, N.Y.	
6. OCCUPATION SALES		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 10-1-1935		9. PLACE OF MARRIAGE NEW YORK, N.Y.		10. NAME OF SPOUSE MARY J. JONES	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. PLACE OF DEATH HOME		14. DATE OF DEATH 4-1-57		15. TIME OF DEATH 10:30 AM	
16. SIGNATURE OF PHYSICIAN J. J. JONES		17. SIGNATURE OF REGISTRAR J. J. JONES		18. SIGNATURE OF WITNESS J. J. JONES		19. SIGNATURE OF WITNESS J. J. JONES		20. SIGNATURE OF WITNESS J. J. JONES	

BUREAU V. S.

APR 08 1957

RECEIVED